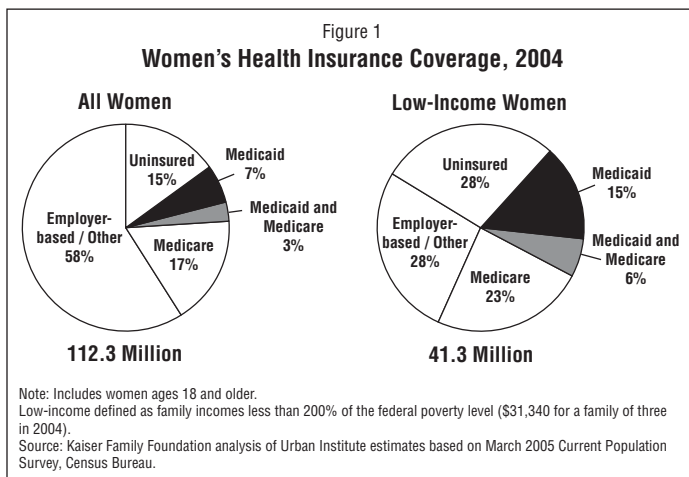


MEDICAID'S ROLE FOR WOMEN

May 2006

Medicaid, the state-federal health coverage program for the poor, provides nearly 19 million low-income women with basic health and long-term care coverage.¹ While often not considered to be a women's health program, women comprise the majority (70%) of adult beneficiaries. Medicaid covers a wide range of health services important to women throughout their lives, including reproductive health care, care for chronic conditions and disabilities, and long-term services.

In 2004, one in ten (10%) women were covered by Medicaid, and for low-income women, Medicaid's role is even more striking, providing assistance to over one in five (21%) (Figure 1). Mothers often obtain coverage for their children's health needs through Medicaid, which now covers one in four American children and finances 37% of all births.²



WHO IS ELIGIBLE?

In order to qualify for Medicaid, women must meet both categorical and income criteria. That means that one must fit into a certain "category" such as being pregnant, a mother of a child under 18, 65 or older, or having a disability. For most of these groups, there are federal minimum income standards, but states can expand coverage beyond these levels, so eligibility varies from state to state.

Medicaid income thresholds for adults are very low. Because women are both more likely than men to fall into one of the eligibility categories and are more likely to be poor, women are more likely to qualify for Medicaid. However, women without dependent children or a disability are unlikely to qualify no matter how poor.

The major Medicaid eligibility categories for adult women are:

Pregnant women: States are required to cover pregnancy-related care for pregnant women with incomes up to 133% of the federal poverty level (FPL), (~\$22,000 for a family of three in 2006) for up to 60 days postpartum. States can cover pregnant women with incomes up to 185% FPL and beyond and still receive federal matching funds.

Parents with dependent children: The income threshold for parents is very low, based on welfare standards, but states can

extend coverage to parents well beyond these levels. As of July 2005, income eligibility levels for working parents ranged from 19% FPL in Alabama and Arkansas to 275% FPL in Minnesota.³

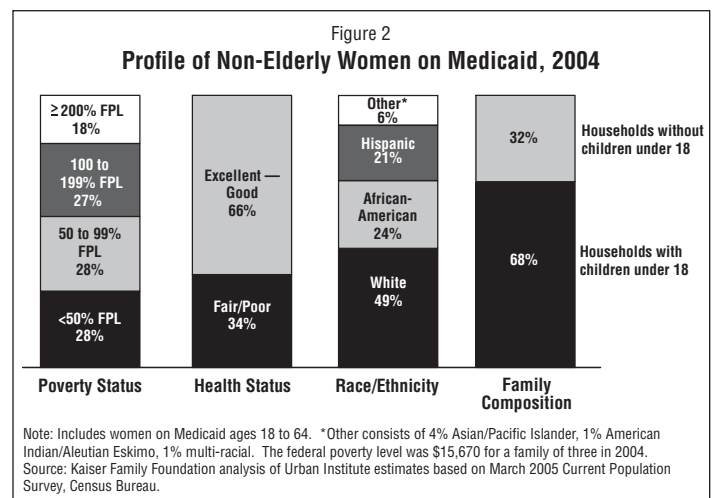
Seniors: Low-income seniors with Medicare who qualify for Supplemental Security Income (SSI) can receive full Medicaid benefits and assistance with Medicare cost-sharing. Low-income seniors who are not poor enough to qualify for SSI can receive some assistance with Medicare cost-sharing and deductibles, but are not covered for long-term services and other Medicaid benefits.

People with Disabilities: Most people with disabilities on Medicaid qualify because they receive Supplemental Security Income (SSI), as they are deemed to have a disability that is so severe that they cannot participate in any "substantial gainful activity." Others can also qualify if they "spend down" their income and assets to meet their state's income threshold or if their medical expenses are so high that they meet their state's optional "medically needy" income standard.

PROFILE OF WOMEN ASSISTED BY MEDICAID

In 2003, over two-thirds (70%) of adults (age 19 and older) on Medicaid were women.⁴ This diverse group of women faces many social and economic challenges that affect their ability to receive timely and quality health care. Women with Medicaid are more likely than the total population to be of reproductive age, poor, minorities, less educated, and parents (Figure 2).

- Almost six in ten (56%) non-elderly women on Medicaid who live in the community have family incomes below the poverty level. Half of these poor women have incomes below 50% of the poverty level, about \$7,800 per year for a family of three.
- Two-thirds (68%) of non-elderly women on Medicaid are raising children under the age of 18.
- One-third (34%) of non-elderly women on Medicaid report fair or poor health, six times the rate of women with private coverage (8%) and almost three times the rate for women who are uninsured (12%).

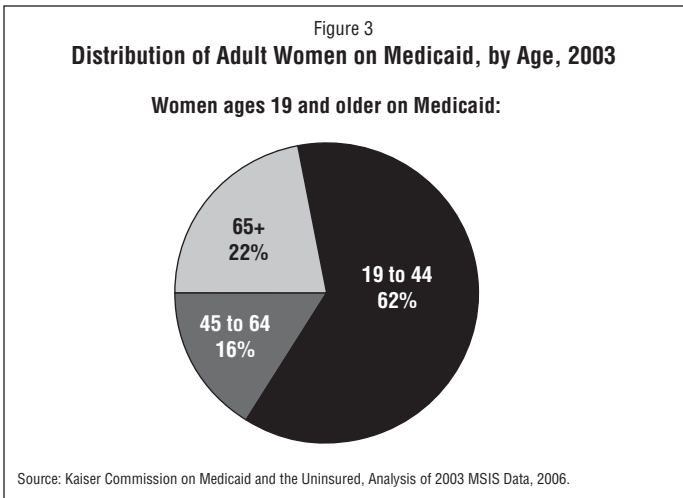


MEDICAID AND WOMEN'S HEALTH ACROSS THE LIFESPAN

Medicaid pays for a broad range of services important to women across the different stages of their lives. This includes hospital and physician services, lab and x-ray services, preventive and screening care, family planning, prenatal care, prescription drugs, and long-term services. The following sections highlight key Medicaid services that are critical during certain life stages.

REPRODUCTIVE YEARS

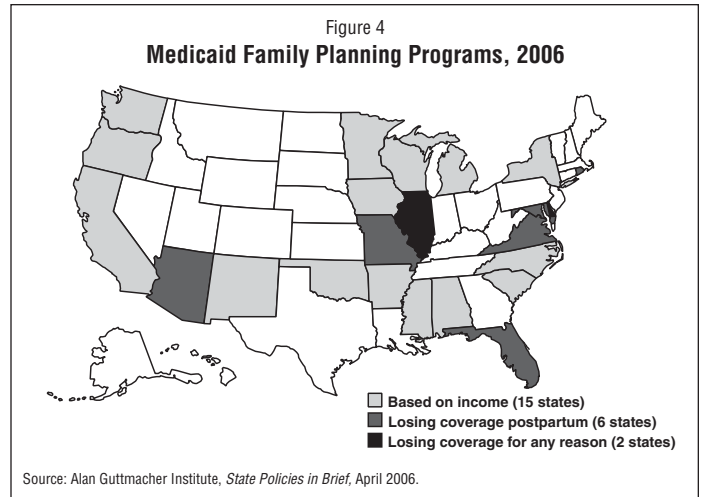
Nearly two-thirds (62%) of adult women on Medicaid are in their reproductive years (19 to 44) (Figure 3). For these women, Medicaid covers a wide range of important services, including family planning, STD testing and treatment, screenings such as pap smears, and pregnancy-related care, (including prenatal services, childbirth, and postpartum care). Medicaid coverage of abortion services, however, is very limited.



Family planning: Family planning is one of a handful of services explicitly mandated by federal Medicaid law. The federal government provides states an enhanced match of 90 cents for every 10 cents they spend on family planning, higher than for other services (typically matched at a rate between 50% and 76%). States can claim this enhanced match for services and supplies that “are expected to achieve a family planning purpose.” Medicaid finances over half of all public funding for family planning services.

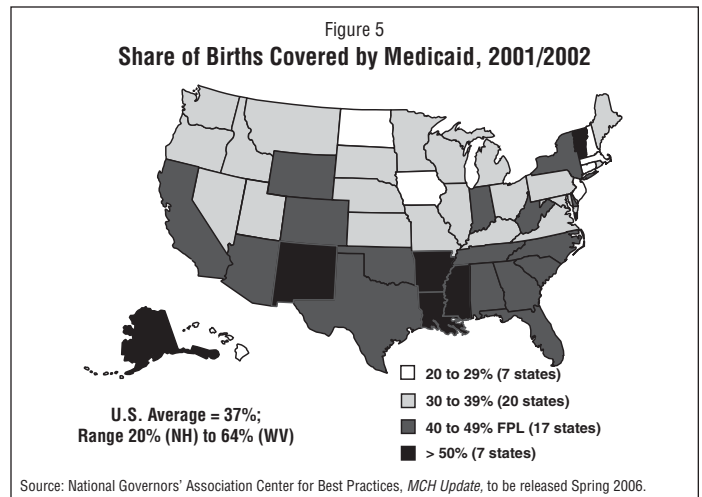
- Under this broad guideline, states routinely cover preventive services and screenings such as prescription contraceptives, pap smears, counseling, and STD testing and treatment, as part of the family planning benefit.
- Family planning services and supplies are mostly exempt from cost-sharing, unlike most other medical services covered by Medicaid. This means women cannot be charged any out-of-pocket costs for these services.
- In recent years, 23 states have expanded Medicaid coverage for family planning services to women who otherwise do not qualify, including low-income women who are not poor enough to qualify for Medicaid and women who have lost Medicaid coverage (Figure 4). In 2001, these programs served 1.7 million women, and recent studies have documented cost savings, reductions in unintended pregnancies, and improved use of family planning services in states with these programs.⁵

Prenatal care and delivery: Responding to greater attention on rising infant mortality, Medicaid eligibility levels were expanded in the late 1980s and 1990s to improve access to prenatal care for low-income women. Today, Medicaid is one of the largest



payers of pregnancy-related services, financing over one-third (37%) of all births in the U.S, and in some states, covering more than half of all births (AK, AR, DC, LA, NM, MS, VT) (Figure 5).

In most states, Medicaid pays for prenatal visits and supplies such as prenatal vitamins, ultrasound and amniocentesis screenings, and delivery services, including vaginal and Caesarean deliveries. Medicaid also covers postpartum care for 60 days. Coverage for other services, such as nutrition counseling, breastfeeding support, transportation services, smoking cessation, and substance abuse treatment are more limited.⁶



Abortion: Medicaid coverage for abortions is very restricted in most states. The federal Hyde Amendment prohibits federal Medicaid spending on abortions, except in cases of rape, incest, or when the woman's life is in danger, and does not make an exception for the health of the woman. Seventeen states choose to use only state funds to provide coverage under very limited circumstances for other “medically necessary” abortions.⁷

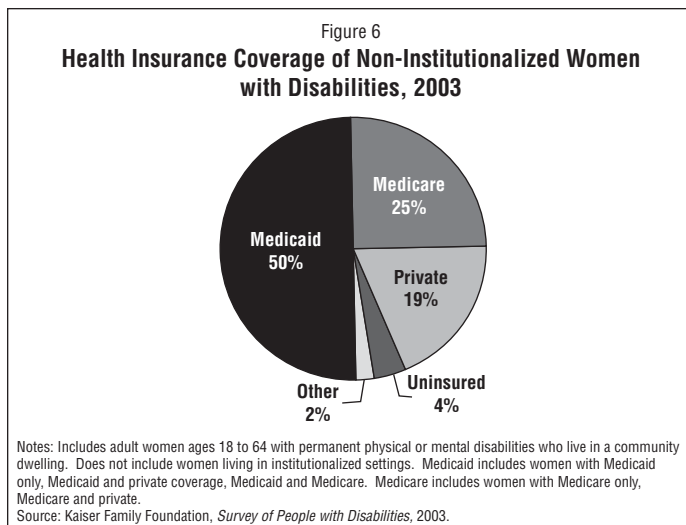
MID-LIFE YEARS

As women age, they have a greater need for screening and treatment of chronic diseases, mental health care, and disability care.

Women with disabilities: Medicaid plays a critical role financing care for women with disabilities, providing assistance with a variety of medical and supportive services. These women have a

broad range of physical and mental disabilities, including physical impairments, severe mental illnesses, and specific conditions such as muscular dystrophy, cystic fibrosis, and HIV/AIDS.⁸ Half of women with disabilities have Medicaid coverage (Figure 6).

Among the benefits that Medicaid covers for women with disabilities are rehabilitation, transportation, and therapeutic services, which help people with disabilities be more self-sufficient and many of which are not covered in private health insurance plans. Long-term services, including home- and community-based care, is another major health benefit for women with disabilities.



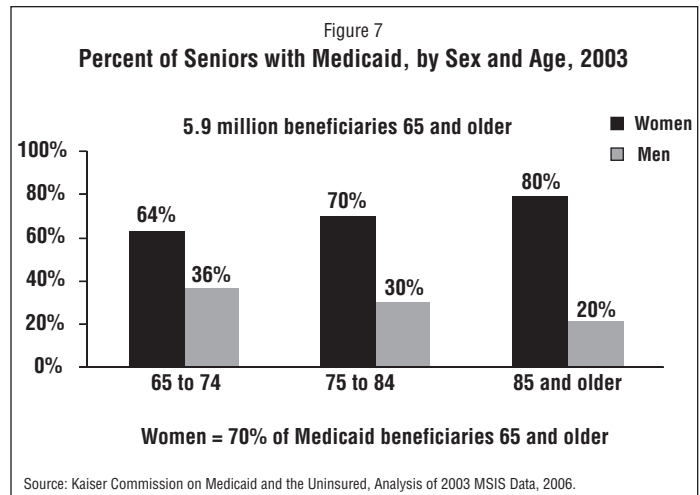
Breast and cervical cancer treatment: In 2000, Congress passed a landmark law in Medicaid's history that allowed states to extend Medicaid coverage to uninsured women with breast or cervical cancer. The program was adopted by nearly all states, although there is considerable variation from state to state in how the program is operated. This program built on a CDC program that offered breast and cervical cancer screening services to low-income and uninsured women, but did not extend coverage for treatment. However, the FY 2007 federal budget proposes a cut of over \$1 million in the screening program, which could limit enrollment in the Medicaid program.⁹

SENIORS

For over 3 million low-income, elderly women, Medicaid supplements Medicare, and provides assistance with long-term care services. Only elderly women who are poor or face catastrophic costs can qualify. Women comprise the majority (70%) of seniors on Medicaid because they live longer and are disproportionately poorer than men (Figure 7).

Medicare beneficiaries: "Dual eligible" beneficiaries, those who receive full Medicaid and Medicare coverage, tend to have extensive health needs and are very poor. Medicaid currently provides them with coverage for long-term services such as nursing home stays, which Medicare does not cover, as well as assistance with Medicare cost-sharing and deductibles. Medicaid also covers several other services that are important for this population, such as rehabilitation, vision, and some dental care. Up until January 1, 2006, Medicaid paid for prescription medicines for dual eligible beneficiaries. The new Medicare drug law has shifted their drug coverage to the new Medicare Part D program.

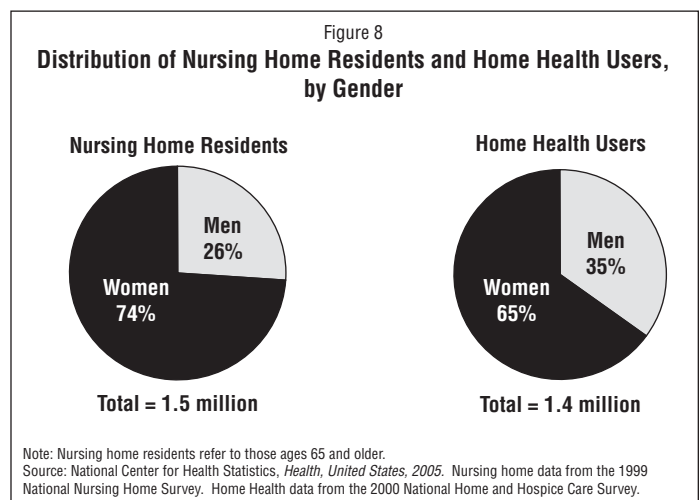
For low-income Medicare beneficiaries with incomes between 74% and 120% of the poverty level (known as Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries), Medicaid's assistance is more limited. These



individuals receive only assistance with Medicare premiums and some of Medicare's cost-sharing requirements.

Long-term services: Women live longer and experience higher rates of chronic illness and disability than men, and thus are more likely to require long-term services in their lifetime. Nearly three-fourths of nursing home residents and two-thirds of people receiving home health care are women (Figure 8). This care can be extremely costly—a year in a nursing home can cost \$70,000 or more—and have devastating economic consequences for women on fixed incomes.

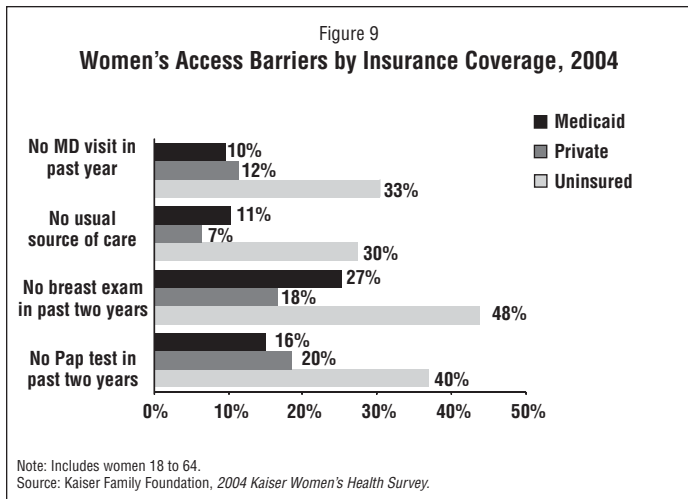
Medicaid finances the care of nearly half (46%) of nursing-home expenditures because Medicare does not provide long-term services coverage, and there is very little coverage in the private market to assist with the high cost of long-term care services. Medicaid also covers home- and community-based long-term services, but coverage for community-based care has been more limited and generally offered through waivers.¹⁰



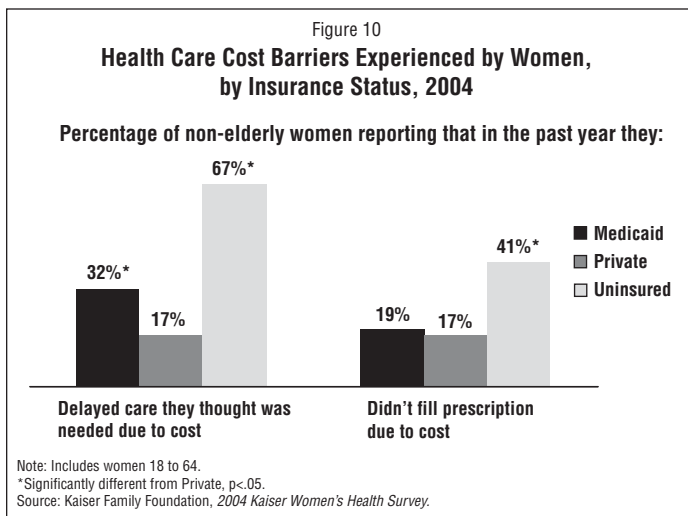
ACCESS TO CARE

Medicaid has been shown to improve access to care for low-income women.¹¹ Compared to their uninsured counterparts, women on Medicaid experience fewer barriers to care and have utilization rates comparable to women with employer-based coverage (Figure 9).

Women on Medicaid are also much less likely to face cost barriers than uninsured women (Figure 10). Nonetheless, affordability is still a problem for a sizable minority of women with Medicaid. One long-standing problem with Medicaid has been limited access to private physicians, particularly specialists. This is due to historical problems with provider participation, largely



a result of the program's low payments to private physicians. Women on Medicaid (28%) are much more likely to report problems seeing a specialist than women with private insurance (11%), as are those who are uninsured (33%).¹² Limited access could particularly compromise care for women with disabilities and ongoing chronic illnesses, as well as women who need obstetric care. Despite these problems, Medicaid remains a critical health care safety-net for low-income women who likely would be otherwise uninsured because they have limited access to employer-sponsored insurance.



LOOKING TOWARDS THE FUTURE

At both the federal and state level, there have been recent efforts to limit total Medicaid, increase the predictability of program spending, and give states more control over the design and scope of their programs. With the passage of the Deficit Reduction Act of 2005 (DRA), states gained substantial new authority to make changes to their Medicaid programs, including changes in benefits and cost-sharing. Further, states are continuing to make major program changes through Medicaid waivers.

Many of the recent changes affect health care coverage for low-income women. The DRA allows states to increase cost-sharing and impose premiums for some beneficiaries. The DRA also permits providers and pharmacists to refuse to provide services or drugs if beneficiaries cannot pay copayments. States are still prohibited from imposing cost-sharing on pregnant women or for

pregnancy-related services. Under the DRA, states can also provide more limited benefits to some Medicaid beneficiaries, which may result in women no longer being covered for important services such as family planning, mental health, or rehabilitation services.

In addition, the DRA includes a provision that requires individuals to produce documentation (usually in the form of a passport or birth certificate) to prove citizenship. This requirement will likely make it more difficult for individuals to obtain and maintain Medicaid coverage and conflicts with earlier efforts adopted by many states to simplify the Medicaid enrollment process.

The DRA also includes a number of provisions that will affect eligibility and access to long-term services. It provides some opportunities to expand community-based long-term care services, but changes in rules regarding the transfer of assets will delay eligibility for Medicaid nursing home coverage. Women are more likely to be affected by these provisions than men since they represent a larger share of nursing home applicants. Also, if their husbands require nursing home coverage, this new policy could affect their ability to maintain assets and economic well-being.

The overall impact of the DRA will depend on how states respond to the new options that are now available. Whatever the total number of people affected, these changes are expected to have a larger impact on women since they represent a disproportionate share of Medicaid enrollees. Changes made through the DRA and state waivers should be carefully evaluated and monitored to determine the impact on the adequacy, availability, and affordability of health care coverage and care for women who rely on Medicaid for their acute and long-term care needs.

ENDNOTES

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